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ABSTRACT

A model program to educate primary care nurse-practitioners for rural areas illustrates successful collaboration between university and rural health settings. Part of the Intercampus Graduate Studies program of the University of California--San Francisco School of Nursing and the University of California--San Diego School of Medicine, the model reflects concern with family health care needs in rural San Diego County. During its first year, Academic Year 85-86, the program established student preceptorships in two rural community health clinics. The university offers didactic content for preparation of the Family Nurse-Practitioner/Nurse-Midwife through its curricular program, selects students for preceptorship placement, provides faculty orientation/development for community/clinical preceptors, provides academic faculty member site visits, and conducts program evaluation. The community health center provides resources/facilities for patient care including preceptor supervision of students and ancillary personnel/supplies and collaborates in program planning/evaluation and preceptor development. The Clinical Preceptor shares patient care sessions with a student, incorporating material specific to rural health. The model demonstrates feasibility of "town/gown" collaboration, promotes job selection based on realities of rural settings, and increases rural community visibility to the university community. Feasibility study results and a map and organization chart of the California Area Health Education Centers systems are included. (LFL)

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PARTNERSHIP IN EDUCATION: PREPARATION OF THE FAMILY NURSE-PRACTITIONER FOR PRIMARY CARE IN RURAL HEALTH SETTINGS

By

Judith T. Fullerton

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Paper presented at the Annual Conference of the National Rural and Small Schools Consortium (Bellingham, WA, October 7-10, 1986).

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Partnership in Education: Preparation of the Family Nurse-Practitioner for Primary Care in Rural Health Settings

The State of California has institutionalized a Master Plan for Higher Education which defines the role of the California state government in the planning and financing of post-secondary education. The Master Plan places the responsibility for graduate, including health professional, education within the structure of the University of California system, a nine-campus network. There are five (5) Schools of Medicine and two (2) Schools of Nursing within the UC system.

The University of California San Diego School of Medicine was established a short eighteen years ago. From its earliest years the School of Medicine recognized its responsibility for articulation with schools and programs of allied health professional education which were affiliated with the School of Medicine in the various health care settings where Faculty and Students provided care. Accordingly the School of Medicine was supportive and instrumental in the development of a program which prepared nurses for practice in the expanded role. The earliest programs of nurse-practitioner education emphasized preparation for the care of children, adults and the school age child.

Both the School of Medicine and the nurse-practitioner educational program which developed within its administrative structure were dedicated from their beginnings to the preparation of primary health care practitioners who were sensitive to the identified needs of the populations which they served in San Diego County. The nurse-practitioner programs, in particular, expanded or contracted their areas of specialty emphasis on the basis of emerging, evolving and evident community need for primary health care.

As the UC San Diego School of Medicine entered the decade of the 1980s the characteristics of the community were in a period of rapid and significant social and demographic change. As a Southern California community San Diego had a significant and growing population of elderly, and an ever intensifying need for alternatives to in-hospital care. Home-health, community day care, and hospice services were proposed and evolving strategies.

As a Southern California community the area was also attractive to the young and the disenfranchised. There was (Is) significant need for health care service to the homeless, and for those addicted to alcohol and drugs.

A very intense period of Indochinese immigration presented a serious challenge to primary health care as San Diego attempted to identify and manage

the chronic illnesses endemic in the several population groups, including tuberculosis, parasitic infestation and the effects of stress and transition.

San Diego as a border community continued to respond to the multiple challenges to health care delivery which were presented by both legal and illegal Hispanic immigration. These challenges are felt most significantly in the area of maternal/child health and the area of migrant health care.

The nurse-practitioner programs supported by the UCSD School of Medicine responded to these community characteristics by development of specialty emphasis programs in Family Primary Care which prepared nurses to address the health care needs of families, school age children, and the elderly, and a program of nurse-midwifery studies. These programs were conducted in a cross-cultural context which meant the incorporation of cultural sensitivity training within the didactic content of the academic program, and the establishment of student preceptorships in settings which served the variety of cultural and ethnic groups. It has always been the belief of the nurse-practitioner programs that student experience within the targeted community and among the cultural and ethnic population groups was one of the best ways to prepare the student for service to those groups.

Again, as the School of Medicine and its nurse-practitioner programs entered the decade of the 1980s both groups took a fresh look at the needs of the community and the appropriate response and direction which should be taken. It was the belief that the nurse-practitioner programs should evolve from their status as continuing education and/or post-baccalaureate certificate educational programs and make the necessary transition to graduate program offerings. The preparation of the nurse-practitioner on the Masters level was intended to prepare the practitioner with the additional skills in nursing leadership and research which would then enable the nurse-practitioner to take a primary role in expansion of service opportunities and settings.

A linkage between the University of California, San Francisco, School of Nursing and the University of California, San Diego, School of Medicine was implemented in the academic year 1983-84. Two programs of nurse-practitioner specialty study were maintained: Family Nurse-Practice and Nurse-Midwifery. The Family Nurse-Practitioner program has only recently been redesigned to a model called the Clinical Specialist in Family Primary Care, and a geriatric clinical emphasis elective added to the specialty course of study.

The Master's program continued in the tradition of its predecessor certificate educational programs in a focus on the preparation of practitioners for service to the primary care deficient, and culturally diverse populations of San Diego County. The program, now called UCSF/UCSD Intercampus Graduate Studies (IGS), also identified a new area of service to which it wished to respond: the family health care needs of rural San Diego County.

IGS applied to the San Diego and Imperial Counties Rural Area Health Education Center for financial support of a feasability study. Area Health Education Centers (AHECs) are federally funded centers which have the mandate of promoting linkages between centers of health professional education and the population needs of several communities. The SIRAHEC focuses on the rural sections of San Diego county and the agricultural desert communities of Imperial County, west of San Diego to the Arizona border. These are areas

in which health care is heavily impacted not only by the issues of availability and access but also by the health effects of occupational pesticide exposures, the nature of agricultural work itself (stoop labor), the character of migrant labor residential facilities (unfortunately, all too often, unsanitary and overcrowded), and seasonal occupational stress.

The purpose of the Feasability study was to investigate the potential for development of a preceptorship experience in a rural health setting. The objectives of the preceptorship itself were similar to those already established in the cross-cultural settings used by Intercampus Graduate Studies, i.e., to provide opportunity for student experience in a setting of specialized health care need, in order to promote competence and confidence of the practitioner for service in such settings.

Funding was received in AY 84-85 (SIRAHEC Grant #PE00053) for the conduct of this feasability study. Criteria for evaluation of thirteen (13) community health clinic settings already established in rural communities were developed. These criteria addressed the risks and benefits which would accrue to both the University and the clinical setting through the establishment of a clinical educational affiliation.

Each setting was evaluated for its ability to offer a quality educational prepceptorship experience to the student: quantity and diversity of patient health care needs addressed in the setting, sufficient space for student clinical practice, educational resources available in the clinical setting (library/reference materials), and the support of administration for the preceptorship experience. The individual practitioners in each setting were evaluated for their interest and ability to conduct the preceptorship supervision and student teaching. IGS was particularly interested in promoting MD/nurse-practitioner collaborative teaching models. Accordingly, nurse-practitioners in each setting were required to possess the Master's degree in order that they might qualify for appointment to the non-salaried clinical Faculty of the School of Medicine (the community Faculty model).

The results of the feasability study were quite gratifying. Two community health settings were identified as appropriate from the University's perspective, and both settings recognized and responded to the benefits which would accrue to them through the University affiliation. Funding was sought and received from SIRAHEC (Grant #PE00053) to support the implementation of the preceptorship. Inter-institutional agreements and Faculty appointments were facilitated, and student preceptorships were inaugurated in AY 85-86. One academic year has been completed and both the University and rural health settings have evaluated the experience as strongly positive, and look forward to continued collaboration.

The program works in the following fashion:

<u>The University</u>

The University offers all general didactic content appropriate to the preparation of the Family Nurse-Practitioner/Nurse-Midwife through its academic curricular program.

The University screens and selects students for preceptorship placement in rural health settings in accord with the goals and objectives stated by the

student. (In AY85-86 several students self-selected the rural health placement as appropriate to their own rural health work objective. We anticipate that our experience will be the same in future years.)

The University provides extensive orientation and faculty development programs for the rural health preceptor through both general (conducted for all community preceptors) and specific (conducted for the rural health preceptors) Faculty Development continuing education programs.

The University provides an academic Faculty member site visitor, on a scheduled basis, to the rural health settings where the Academic Faculty

- provides consultation/collaboration to the community preceptor
- conducts additional student evaluation
- consults with administration regarding progress of the preceptorship

The University conducts program evaluation and provides feedback to the community setting.

The Community Health Center

Administration of the community health setting provides the resources and facilities for a patient care session. This includes not only the services of the preceptor for student supervision but also the ancillary personnel and supplies essential to patient care. Administration is cognizant that a Student/Preceptor team will see a lessened volume of patients per clinical session, in order to accomodate student teaching/learning/evaluation.

The Clinical Preceptor shares a patient care session with the student, incorporating, where and when relevant, the additional didactic material specific to the rural health focus of the patient's presenting problem. In the first years of this project funding has been received by the community setting to offset the salary of the Clinical Preceptor, with the understanding and objective that such financial support will decrease as the preceptorship becomes "institutionalized" into the community clinic model of patient care. Revenue generated by the patient care activity is retained by the clinical setting.

The Clinical Preceptor offers academic service to the University by guest lectureship, addressing the adaptation of primary care skills to the specific health care needs and challenges of the rural health setting.

Both Administration and Clinical Preceptor dedicate additional uncompensated time to the program planning, preceptor development and program evaluation activities essential to the excellence of the student learning experience.

Intercampus Graduate Studies recognizes that this model is neither particularly innovative nor unique. Rather, we present our development and implementation of this model as one more demonstration of the feasability of the "town/gown" collaborative endeavors which benefit both academia and the community. In this example we offer a model for the education of a primary care nurse-practitioner. The practitioner's role in the rural health setting

can be in the community health center, the school, or the home. We believe that student preceptorship experience in settings which emphasize the reality of the community, of the population, of the particular health care needs experienced by residents of the community and the cultural values of the population to be served is one very valuable way to promote the selection of such settings as the place of work, and, in that fashion, to address the needs of health manpower distribution. The other facet of such consciousness-raising is, of course, the increased visibility of the rural community, and the special needs of those communities, to University academia. We believe that the risks of reaching out are far outweighed by the benefits of touching.

TABLE 1

STRAHEC FEASIBILITY STUDY - PHASE I FINAL REPORT

Criteria & Key

(p) of primary importance
(s) of secondary importance
(+) satisfactory
(-) unsatisfactory

		Borrego Springs	El Cajon	Escondido	Mountain Health Boulevard	Oceanside	Pauma Valley Indian Health Ctr	Ramona	San Dieguito	San Marcos	Santa Ysabel	Sycuan Indian Health Center	Valley Center	Vista
Distance from CTF ≤ 60 miles RT	(p)	-	+	+	-	+/-	-	+/-	+	+/-	-	+	+/-	+
Clinical Facilities Appropriate to Student Learning	(p)	+	+*	+	-	+	+	+	+	+	-	+	+	+*
Broad Demographic Pt. Population	(p)	+	+	-	+/-	+	+	+	+	+	+	+	+	+
Broad Variety of Patient Illness/ Health Service	(p)	+	+	+	+	+	+	+	+	+	+	+	+	+
Adequate Patient Volume	(p)	+	+	+	+/-	+	+	+	+	+	+/-	+	+	+
Appropriate Hours of Operation	(p)	+	+	+	+	+	+	+	+	+	+	+	+	+
Viability of Site for Foreseeable Future	(p)	+	+	-	+/-	+	+	+	+	+	+	+	+	+
Supportive Administration	(p)	+	+	+	+	+	+	+	+	+	+	+	+/-	+
M.D. Preceptor Willing/ Appropriate/Stable	(p)	-	?	+/-	-	-	?	-	+/-	+	-	+	-	+
N.P. Preceptor Willing/ Appropriate/Stable	(p)	+**	+	+/-	-**	+	+	-	+	+	+	+	+	+
One Exam Room for Student Use	(p)	+	+	+	+	+	+	+	+	+	-	+	+	+
Conference Room for Student Use	(s)	+	+	+	+	+	+	+	+	+	-	+	+	+
Resource Materials in Clinic	(s)	+/-	+/-	+/-	+/-	+/-	+/-	+/-	+/-	+	-	+	+/-	+
Previous Students in Setting	(s)	-	+	+	-	+	-	+	+	+	-	+	+	+
Chart System Adaptable/Flexible to POMR Format	(s)	+	+	+	+	+	+	+	+	+	+	+	+	+

* New site - Spring, 1985
** Credentials only

Goal

The goal of the California AHEC System is the same as that of the national AHEC program expressed in Public Law 94-484:

> **For the purpose of improving the distribution, supply, quality, utilization, and efficiency of health personnel in the health services delivery system AND for the purpose of encouraging the regionalization of educational responsibilities of health professions schools...**

The California project has specific goals for each health discipline but has special emphasis on improving the distribution of primary care physicians and registered nurses and on improving access to care for rural citizens and the largely minority population of the inner-city areas.

Table 2

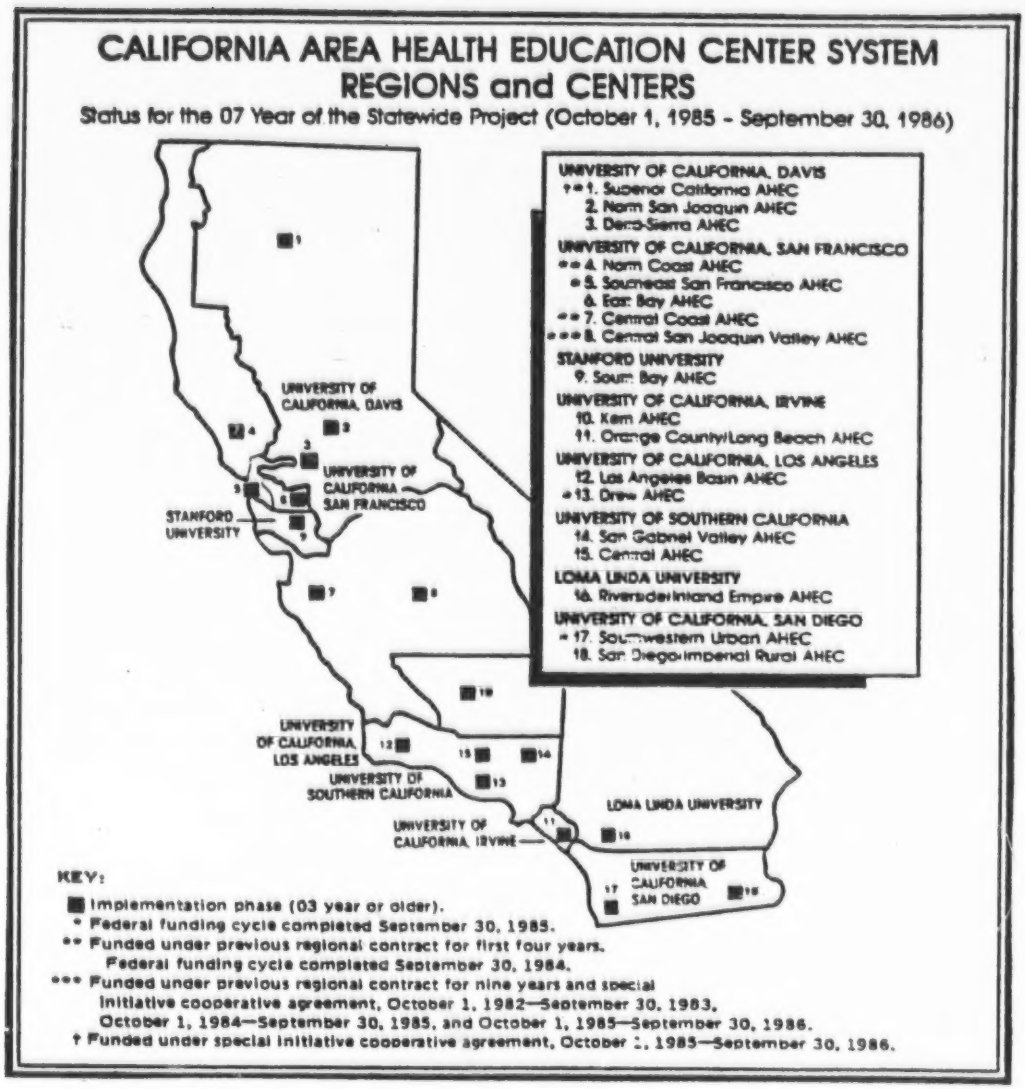
CALIFORNIA AREA HEALTH EDUCATION CENTER SYSTEM
REGIONS and CENTERS
Status for the 07 Year of the Statewide Project (October 1, 1985 - September 30, 1986)
UNIVERSITY OF CALIFORNIA, DAVIS
†••1. Superior California AHEC
2. North San Joaquin AHEC
3. Delta-Sierra AHEC
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
••4. North Coast AHEC
•5. Southeast San Francisco AHEC
6. East Bay AHEC
••7. Central Coast AHEC
•••8. Central San Joaquin Valley AHEC
STANFORD UNIVERSITY
9. South Bay AHEC
UNIVERSITY OF CALIFORNIA, IRVINE
10. Kern AHEC
11. Orange County/Long Beach AHEC
UNIVERSITY OF CALIFORNIA, LOS ANGELES
12. Los Angeles Basin AHEC
•13. Drew AHEC
UNIVERSITY OF SOUTHERN CALIFORNIA
14. San Gabriel Valley AHEC
15. Central AHEC
LOMA LINDA UNIVERSITY
16. Riverside/Inland Empire AHEC
UNIVERSITY OF CALIFORNIA, SAN DIEGO
•17. Southwestern Urban AHEC
18. San Diego-Imperial Rural AHEC
UNIVERSITY OF CALIFORNIA, DAVIS
STANFORD UNIVERSITY
UNIVERSITY OF CALIFORNIA SAN FRANCISCO
UNIVERSITY OF CALIFORNIA LOS ANGELES
UNIVERSITY OF SOUTHERN CALIFORNIA
UNIVERSITY OF CALIFORNIA, IRVINE
LOMA LINDA UNIVERSITY
UNIVERSITY OF CALIFORNIA SAN DIEGO
KEY:
Implementation phase (03 year or older).
• Federal funding cycle completed September 30, 1985.
•• Funded under previous regional contract for first four years. Federal funding cycle completed September 30, 1984.
••• Funded under previous regional contract for nine years and special initiative cooperative agreement, October 1, 1982—September 30, 1983, October 1, 1984—September 30, 1985, and October 1, 1985—September 30, 1986.
† Funded under special initiative cooperative agreement, October 1, 1985—September 30, 1986.

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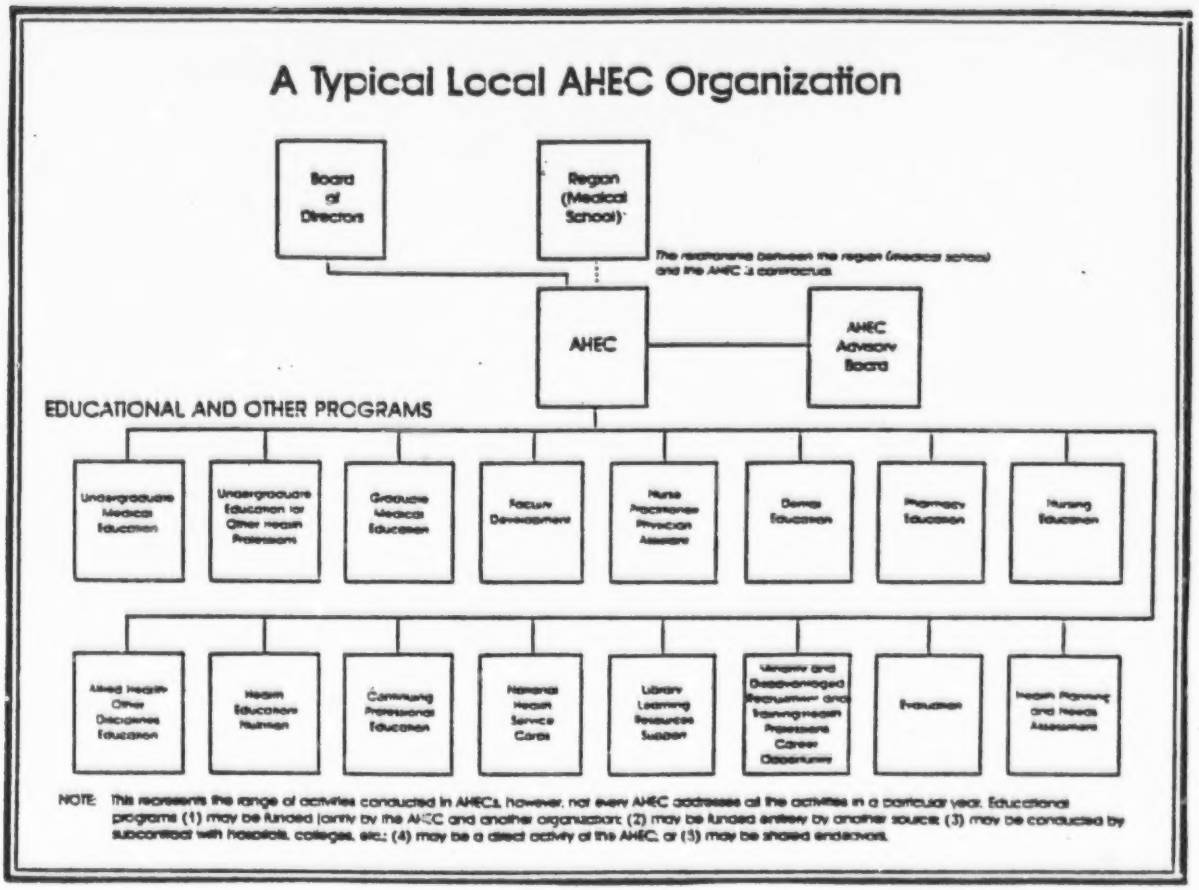
Table 3


A Typical Local AHEC Organization
Board of Directors
Region (Medical School)
AHEC
AHEC Advisory Board
EDUCATIONAL AND OTHER PROGRAMS
Undergraduate Medical Education
Undergraduate Education for Other Health Professions
Graduate Medical Education
Faculty Development
Nurse Practitioner Physician Assistant
Dental Education
Pharmacy Education
Nursing Education
Allied Health Other Disciplines Education
Health Education Network
Continuing Professional Education
National Health Service Corps
Library Learning Resources Support
Minority and Disadvantaged Recruitment and Training/Health Professions Career Opportunity
Evaluation
Health Planning and Needs Assessment
NOTE: This represents the range of activities conducted in AHECs; however, not every AHEC addresses all the activities in a particular year. Educational programs (1) may be funded jointly by the AHEC and another organization; (2) may be funded entirely by another source; (3) may be conducted by subcontract with hospitals, colleges, etc.; (4) may be a direct activity of the AHEC; or (5) may be shared endeavors.

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